PARK CEDAR
DENTISTRY

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessment and physician certifications

I acknowledge that I have read your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

Office use only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices but was unable to do so as documented below:

Date	Initials	Reason
_____	_____	_____

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